DEPARTMENT OF PUBLIC HEALTH NURSING

IN CHARGE OF

EDNA L. FOLEY, R.N.

ADMINISTRATIVE MEASURES FOR THE RELIEF OF EPIDEMIC CONDITIONS, WITH SPECIAL REFERENCE TO INFLUENZA[1]

The Committee on Administrative Measures for Relief would submit the following considerations as constituting a summary of the important measures for meeting epidemic conditions:

I. GENERAL RULES

1. Compulsory reporting of all cases of influenza and pneumonia.
2. Isolation, by coöperation and education, to a point where it does not diminish the willingness of the physician to report.
3. Placarding would seem to be subject to the same limitations as is isolation.
4. The closing of schools, prohibition of funerals, etc., being preventive measures, are not touched upon in this report, except to mention that the closing of many agencies will release medical, nursing, and volunteer services for special influenza work.
5. It may be necessary to grant authority to the health authorities to administer relief.

II. PRELIMINARY MEASURES

1. The listing and distribution of resources, including physicians, nurses, social workers, nurses' aids, clerks, domestics, laundresses, automobiles, chauffers, mask makers and volunteers of all kinds. All available publicity channels should be used to promote volunteer service. An appeal should be made for voluntary donors of human blood serum for convalescent influenza patients, to be held in readiness for use in treatment.
2. The centralization of resources, under one control, with central and branch headquarters, the city being districted for medical, nursing and other work. The central headquarters should be ordinarily under the supervision of a board representative of the most important agencies concerned, the board's work to be administered through a manager (presumably the health officer) selected for his fitness.
3. The service should be maintained on a 24-hour basis, and a system of outgoing and incoming telephone service is essential.

[1] First report of Sub-committee of American Public Health Association.

4. The local authorities should get and keep in touch with state and national agencies.

III. Current and Continuous Analysis of Case Situation

1. In the smaller communities a canvass should be made of all physicians, soliciting information as follows: (a) Number of cases under care; (b) number of cases needing hospital treatment; (c) number of cases needing home nursing care; (d) number of cases requesting medical service but not reached. This information will indicate the situation as regarding the need for emergency nursing and medical service, and should be acquired as fully as possible in larger communities, through various agencies. The continuous classification of cases according to these groupings is of practical value.

IV. Analysis, Augmentation and Organization of Principal Facilities

(A) *Field Nursing.*

1. Ordinarily nursing facilities utilized in general public health work should be diverted to meet the epidemic situation, and should be used on a district basis, with all other available facilities, under one supervision.

2. Nursing assistants, volunteers, etc., should be used wherever possible in homes and institutions, under expert supervision, after classification and assignment on a basis of minimum standards as to fitness, etc.

3. Restriction, so far as possible through the pressure of public opinion, should be brought against the unnecessary use of private nurses.

4. Automobile transportation should be provided, and the nursing service used to encourage isolation and education.

5. Special record forms are essential for this and the medical work, and a special sub-committee is proposed to meet this problem.

6. Provision as to housing and care should be made for out of town nurses.

(B) *Emergency Medical Service.*

1. The medical service should be handled through the central office, the physicians being responsible to the central office, though perhaps assigned to district offices.

2. In this emergency service there should be utilized all available physicians, such as school and factory physicians, volunteers, practitioners on a paid basis, etc. This service should cover all calls reported as unreached by private physicians or received through other channels, and should be coördinated with the special nursing service,

being provided with automobile transportation, machines being hired if necessary.

3. The emergency medical service should be used to select cases needing hospital care.

4. It may be feasible to institute a central clearing house in certain districts for private physicians' calls.

5. An arrangement should be made through the medical licensing board for the granting of temporary permits to practice, to reputable physicians from out of the state, at the request of the Central Influenza Committee.

6. In some localities it may be feasible to district the local practitioner and to have him meet special calls on a part-time basis for adequate compensation.

7. Certain of the relatively non-essential specialities should be discouraged, and the physicians in those specialities urged to volunteer for emergency district work. This type of service may be operated on a pay or free basis.

8. Presumably some effort should be made, through an authoritative medical commission, to suggest standard methods of treatment, and wise limitations as to therapeutic procedure.

(C) *Hospital Facilities.*

1. It is essential that the facilities, if possible, be kept ahead of the demand. A daily canvass should be made and data collected regarding available beds, medical and nursing needs, domestics, food, cots, supplies, etc. A regular visit by an inspector will probably prove more effective than an attempt at telephone communication.

2. Under most conditions a central clearing house, covering most if not all of the hospitals, is advisable for the admission of cases. Through this channel the severer cases may receive first consideration. Owing to constant changes in the hospital bed situation, the daily canvass of facilities may not be wholly depended upon; on the contrary, it may usually be necessary to telephone the hospital in order to make sure regarding the admission of a particular case. In any event the hospitals should be impressed with the necessity for admitting only the most severe or needy cases, pay or free.

3. It is advisable to add wards or tents or new equipment to existing institutions rather than to establish entirely new emergency hospitals.

4. Non-emergency surgical and chronic medical cases amenable to home treatment should be dehospitalized.

5. A convalescent home, if adjacent to the hospital, may serve for the care of mild and convalescent cases, thereby increasing the

space in the hospital for acute cases, obviously involving an increase in the nursing facilities.

6. A canvass of ambulance facilities should be made, ambulances being requisitioned with payment, or hired by contract, if necessary. Automobiles and motor trucks should be potentially mobilized for this purpose. Frequently military equipment may be used if accessible.

V. Social and Relief Measures

1. The central office should keep the family advised regarding the patient, thereby saving telephone calls, trolley fares and worry on the part of the family, and increasing the willingness for hospitalization.

2. Volunteer workers such as Red Cross volunteers, teachers, relatives, etc., should be placed in care of families where the responsible members are dead or hospitalized, this service being under expert social supervision, and the families in touch with the supply system.

3. Precaution should be taken that institutions and families too busy with the influenza situation to look after their own needs, are covered by the general relief measures.

4. Ordinary charitable relief should be handled through the routine agencies, the service coördinated with the other epidemiological measures. Churches, lodges, etc., should be urged to handle their own cases, in order to relieve the pressure on the central agency. Aid should be immediate, without protracted investigation.

5. Recreation facilities (motoring, etc.) should be provided for the physicians and nurses while off duty.

VI. Food

1. Available central cooking facilities should be used so far as is necessary, such as the dietetic equipment in high schools, normal schools, colleges, etc., with a delivery system to families and institutions in need.

2. Individual families should be encouraged to cook additional amounts, the same to be delivered to cases in need, a standard list of prepared foods needed being devised and advertised, with recognition for racial customs and preferences.

3. It may be necessary to establish canteens in sections of the city.

VII. Laundry

1. A special collection and distribution system may be essential both for homes and institutions.

2. It may be necessary to take over a public laundry with compensation, or a private non-medical institutional laundry.

VIII. Provisions for Fatalities

1. Death reporting should be prompt (24 hours) and a record kept, so as to insure prompt disposal of bodies.

2. A daily canvass of available coffins should be made, labor assured for construction, and possibly no coffins sold without the permit of the Influenza Administration Office.

3. If morgue facilities are inadequate, a central place should be provided, with embalming facilities, for the temporary disposal of bodies.

4. A canvass of hearses should be made and regulations issued prohibiting unnecessarily long hauls, insisting on maximum capacity loads, etc. A central control will prevent unnecessary duplication as to routes, etc.

5. A reserve supply of trucks and automobiles should be at hand for use in various ways in connection with the handling of fatal cases.

6. The number of graves required should be estimated and labor released from public works or secured through other channels (possibly military) for digging.

IX. Education, Instruction and Publicity

Literature and special instructions will be necessary on many phases, including the following:

1. Instructions to physicians as to reporting, facilities available, district arrangements, etc.

2. Advice to physicians regarding treatment standards and suggestions.

3. Instructions for families, to be distributed by nurses, physicians, social workers, druggists, etc., covering the problems of care during the physician's absence.

4. Instructions to the public as to where aid may be secured, to be printed in various languages, and distributed by druggists, displayed in street cars, used in the press, etc.

5. Instructions for families on "What to do till the doctor comes."

6. Instructions to physicians, factory managers, school superintendents, etc., urging the necessity for immediate home and bed treatment at the first sign of respiratory disease.

7. Popular literature on the essentials of adequate care, the danger for returning to work too soon, etc. Popular press space is worth paying for, if it cannot be secured otherwise.

8. Popular publicity as to legitimate medical, nursing, undertaker, drug, and other charges, to prevent profiteering.

X. Miscellaneous

1. The coöperation of pharmaceutical agencies should be secured to insure an adequate supply of drugs, vaccines, and druggists.

2. Influenza victims and their families should have "first call" on fuel deliveries.

3. While follow-up procedures are not legitimately a factor in the epidemic situation, their consideration is essential to an adequate meeting of the entire problem. This means adequate provision for medical examination and nursing care, relief measures, industrial employment problems, the follow-up of special sequellae such as cardiac affections, tuberculosis, etc.

(Signed) Sub-committee:
D. B. Armstrong, M.D., *Chairman,* Framingham, Mass.
William C. Woodward, M.D., *Vice Chairman,* Boston, Mass.
Edna L. Foley, R.N., Chicago, Ill.
Eunice H. Dyke, R.N., Toronto, Ontario, Canada.

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NATIONAL HEALTH TOURNAMENT

February will be a great month in the health educational field. The school children of the United States, answering the unique summons of the Junior Red Cross and the National Tuberculosis Association, will go into training as Modern Health Crusaders and will test their prowess in health knighthood. The whole country becomes a Field of the Cloth of Gold in the new chivalry—health chivalry. Staged in the National Tournament will be state, county and city tournaments conducted by state and local tuberculosis associations. The period of contest is the fifteen weeks from February 9th through to May 24th.—Bulletin of the National Tuberculosis Association.